



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 11, 2009

Russell McCoy
South Bannock Group Home
415 South Arthur
Pocatello, ID 83204-3317

RE: South Bannock Group Home, provider #13G015

Dear Mr. McCoy: *Russ*

This is to advise you of the findings of the Medicaid/Licensure survey of South Bannock Group Home, which was conducted on August 6, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Russell McCoy
August 11, 2009
Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 24, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

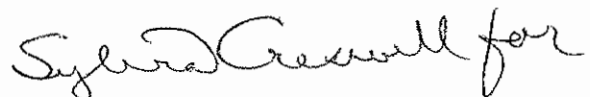
This request must be received by August 24, 2009. If a request for informal dispute resolution is received after August 24, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures



August 21, 2009

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Nicole:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for South Bannock Group Home from the survey completed August 6, 2009. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed above.

Sincerely,



Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

RECEIVED
AUG 24 2009
BUREAU OF FACILITY
STANDARDS

Russell C. McCoy, Executive Director • rmccoy@ida.net

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2009
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NAME OF PROVIDER OR SUPPLIER

SOUTH BANNOCK GROUP HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

**3875 SOUTH BANNOCK HIGHWAY
POCATELLO, ID 83201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Jim Troutfetter, QMRP Common abbreviations/symbols used in this report are: IPP - Individual Program Plan LPN - Licensed Practical Nurse	W 000		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure individuals' adaptive equipment was kept in good repair for 1 of 3 individuals (Individual #2) who required bed rails. This resulted in an individual's bed rails being in disrepair. The findings include: 1. Individual #2's 7/14/09 IPP stated he was a 21 year old male whose diagnoses included profound mental retardation, spastic quadriplegia, and seizure disorder. During an observation on 8/4/09 from 6:00 - 8:30 a.m., Individual #2's bed was noted to be	W 436	W436 483.470(g)(2) For Individual #2, the facility has fixed the bed rail. The RPD will review and revise the Weekly Adaptive Equipment Checklist to ensure all adaptive equipment items are on the form. The ATS completes this form on a weekly basis. Corrective Action Completion Date: September 15, 2009 Person Responsible: Jamie L. Anthony, Residential Program Director and Christina Zausch, Active Treatment Specialist RECEIVED AUG 24 2009 BUREAU OF FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *[Signature]* *08/21/09*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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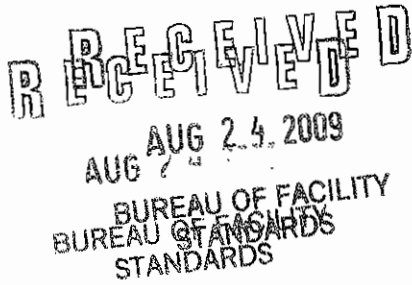
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2009
NAME OF PROVIDER OR SUPPLIER SOUTH BANNOCK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3875 SOUTH BANNOCK HIGHWAY POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 436	Continued From page 1 equipped with bed rails. The bed rails were lowered and a toothette (a disposable mouth swab) was noted to be placed through the bottom locking holes of the bed rail. The LPN, who was present during the observation, stated she was not sure why the toothette was placed through the holes and removed it. At that time, it was noted the bed rail was missing the locking mechanism to keep the bed rail in the up position. At that time, the LPN instructed a staff member to have the rails replaced. During an environmental survey on 8/5/09 from 12:00 - 1:05 p.m., Individual #2's bed rail was noted to still be missing the locking mechanism to keep the bed rail in the up position. The maintenance staff, who was present during the environmental survey, stated he was not aware the rail was broken. The facility failed to ensure Individual #2's bed rails were in proper working order.	W 436			
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases for 5 of 8 individuals (Individuals #1, #2, #3, #6, and #7) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include:	W 455	W455 483.470(I)(1) For individuals #1, 2, 3, 6 and 7 new caddies were purchased that have separated compartments so the tooth brushes are stored away from other items. For all other individuals in the facility, they too received new caddies. The ATS will purchase a cover system for all of the tooth brushes in the home. The RPD will add this item to the Weekly Home Inspection. Corrective Action Completion Date: September 15, 2009		

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W 455	<p>Continued From page 2</p> <p>1. An environmental survey was conducted in the facility on 8/5/07 from 12:00 - 1:05 p.m. During that time, it was noted individuals' hygiene kits contained uncovered toothbrushes mixed with other hygiene products as follows:</p> <ul style="list-style-type: none"> - Individual #1: an uncovered tooth brush was stored with an uncovered tooth flossing device, a container of deodorant, and a bottle of after shave. - Individual #2: an uncovered toothbrush was stored with two containers of deodorant, a bottle of after shave, and an ear syringe. - Individual #3: an uncovered toothbrush was stored with a container of deodorant and a bottle of after shave. - Individual #6: an uncovered toothbrush was stored with a container of deodorant, an electric razor, and a nail brush. - Individual #7: an uncovered toothbrush was stored with an uncovered tooth flossing device, a razor, and two containers of deodorant. <p>The Home Manager, who was present during the environmental survey, stated the toothbrushes should have covers.</p> <p>The facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases.</p>	W 455	<p>Person Responsible: Jamie L. Anthony, Residential Program Director and Christina Zausch, Active Treatment Specialist</p>		

Bureau of Facility Standards

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MM266	<p>16.03.11.100.03(a) Garbage Containers</p> <p>All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material and shall not leak or absorb liquids. Containers must be provided with tight-fitting lids.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all containers used for storage of garbage and refuse were provided with tight-fitting lids for 8 of 8 individuals (Individuals #1 - 8) residing in the facility. The findings include:</p> <p>1. An environmental survey was conducted on 8/5/09 from 12:00 - 1:05 p.m. During that time, three garbage cans in the garage were noted to be without lids. The garbage cans contained recycling materials, including plastic and metal food containers. The Home Manager, who was present during the environmental survey, stated the cans should have lids.</p> <p>The facility failed to ensure garbage cans used in the facility were provided with tight-fitting lids.</p>	MM266	<p>MM266 16.03.11.100.03(a)</p> <p>The garbage containers have been provided with tight-fitting lids. To ensure this deficiency does not occur again, the facility will add this to the Weekly Home Inspection in which the Active Treatment Specialist will complete.</p> <p>Corrective Action Completion Date: September 15, 2009</p> <p>Person Responsible: Jamie L. Anthony, Residential Program Director and Christina Zausch, Active Treatment Specialist</p>	
MM380	<p>16.03.11.120.03(a) Building and Equipment</p> <p>The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the</p>	MM380	<p>MM380 16.03.11.120.03(a)</p> <p style="text-align: center;">  </p>	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Executive Director

(X6) DATE

08/21/09

6899

N4LF11

If continuation sheet 1 of 4

Bureau of Facility Standards

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MM380	<p>Continued From page 1</p> <p>facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include:</p> <p>During an environmental survey conducted on 8/5/09 from 12:00 - 1:05 p.m., the following concerns were noted:</p> <ul style="list-style-type: none"> - The outside light by the door at the end of the hall was missing the bulb. - Individual #4's foot board had a 6 inch by 8 inch hole. - There was a 3 foot by 2 foot patched section of wall beside Individual #4's bed that was missing paint. - There was a 6 inch by 6 inch hole in the wall to the right of Individual #4's bedroom window. - There was black mold along a two-and-a-half foot section of tile at the head of the bathtub. - There was an 8 inch by 12 inch patched section of wall to the right of the toilet in the bathtub room that was missing paint. - The front and back veneer of the door to the linen closet was separating from the core, and the door was hanging loose on the hinges, preventing the door from closing properly. - There were multiple patched areas on the wall behind and to the left of the couch in the living room that were missing paint. - The outside light by the living room door, and the outside light by the kitchen door, were both 	MM380	<p>The outside light bulb will be replaced.</p> <p>Individual #4's foot board will be replaced</p> <p>The 3 foot by 2 foot patched section of wall beside Individual #4's bed will be painted.</p> <p>The 6 inch by 6 inch hole in the wall to the right of Individual #4's bedroom window will be fixed and painted.</p> <p>This section of the bathtub will have the caulking removed, the area cleaned and caulking replaced.</p> <p>The 8 inch by 12 inch patched section of wall to the right of the toilet in the bathtub room will be painted.</p> <p>The door to the linen closet will be replaced.</p> <p>The multiple patched areas on the wall behind and to the left of the couch in the living room will be painted.</p> <p>The outside light by the living room door</p>	

MM380 16.03.11.120.03(a)

The outside light bulb will be replaced.

Individual #4's foot board will be replaced

The 3 foot by 2 foot patched section of wall beside Individual #4's bed will be painted.

The 6 inch by 6 inch hole in the wall to the right of Individual #4's bedroom window will be fixed and painted.

This section of the bathtub will have the caulking removed, the area cleaned and caulking replaced.

The 8 inch by 12 inch patched section of wall to the right of the toilet in the bathtub room will be painted.

The door to the linen closet will be replaced.

The multiple patched areas on the wall behind and to the left of the couch in the living room will be painted.

The outside light by the living room door

The garbage containers have been provided with tight-fitting lids. To ensure this deficiency does not occur again, the facility will add this to the Weekly Home Inspection in which the Active Treatment Specialist will complete.

Corrective Action Completion Date: September 15, 2009

Person Responsible: Jamie L. Anthony, Residential Program Director and Christina Zausch, Active Treatment Specialist

MM266 16.03.11.100.03(a)

Bureau of Facility Standards

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MM380	Continued From page 2 missing covers. - The carpeting throughout the facility was stained and worn, and there were several bleached areas.	MM380	and the outside light by the kitchen door will receive new covering. The carpet in the facility is scheduled to be replaced the first quarter of 2010.	
MM426	16.03.11.120.10(a) Plumbing Fixtures All plumbing fixtures must be clean and in good repair. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all plumbing fixtures were kept in good repair for 8 of 8 individuals (Individuals #1 - 8) residing in the facility. The findings include: 1. During an environmental survey on 8/5/09 from 12:00 - 1:05 p.m., it was noted the sink in the tub bathroom drained slowly. When the water was turned on, the sink filled to the overflow drain within 45 seconds. The maintenance staff, who was present during the environmental survey, stated the drain was clogged. 2. During an environmental survey on 8/5/09 from 12:00 - 1:05 p.m., the shower head in the shower bathroom was noted to be continuously dripping, causing the floor in front of the shower to be wet. The faucet to the shower head would not shut off completely. The maintenance staff, who was present during the environmental survey, stated he had just become aware of the faucet leaking. The facility failed to ensure the plumbing fixtures were kept in good repair.	MM426	To ensure that these problems to recur, the Weekly Home Inspection will be revised to include the areas of concern listed above. Corrective Action Completion Date: October 30, 2009 Person Responsible: Sam Guyette, Physical Facilities Manager and Jamie L. Anthony, Residential Program Director MM426 16.03.11.120.10(a) The sink will be fixed so that it will drain properly. The showerhead will be fixed so that it does not continuously drip. To ensure that these problems to recur, the Weekly Home Inspection will be revised to include the areas of concern listed above. Corrective Action Completion Date: October 30, 2009 Person Responsible: Sam Guyette, Physical Facilities Manager and Jamie L. Anthony, Residential Program Director	

Bureau of Facility Standards

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MM429	16.03.11.120.11 Equipment and Supplies for Resident Care Equipment and Supplies for Resident Care. Adequate and satisfactory equipment and supplies must be provided to enable the staff to satisfactorily serve the residents. This Rule is not met as evidenced by: Refer to W436.	MM429	MM429 16.03.11.120.11 Please refer to W436		
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	MM769 16.03.11.270.03(c)(vi) Please refer to W455		